

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011	
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN46222			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: April 25, 26, 27, & 28, 2011</p> <p>Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510</p> <p>Survey Team: Courtney Hamilton, RN TC Connie Landman, RN Diana Zgnoc, RN Christi Davidson, RN</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 7 Medicaid: 47 Other: 9 Total: 63</p> <p>Sample: 15 Supplemental Sample: 1</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0223 SS=A	<p>Quality review completed on May 4, 2011, by Bev Faulkner, RN</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse (Resident #130 and Social Services Director [SSD])</p> <p>Findings include:</p> <p>A current facility policy, undated, provided by the Administrator on 04/27/2011 at 9:00 A.M., titled "Primary Policy Abuse Prohibition" indicated "it shall be the policy of the Alpha Home to assure that all residents of this facility are free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion."</p> <p>Resident #130's record was reviewed on 04/26/2011 at 4:40 P.M., diagnoses included but were not limited to incomplete quadriplegia, recurrent UTI (urinary tract infections), neurogenic bowel and bladder, and muscle spasms.</p>			F0223	<p>It is the policy of the Alpha Home to ensure residents are free from verbal abuse, and that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown origin, misappropriation of resident property are immediately reported to the administrator, who then reports to ISDPH. Corrected Action related to this finding: This incident was reported to the ISDPH within the required time frame. The staff person received corrective action documentation. The Alpha Home brought in an outside consultant to interview the resident, to ensure the resident felt safe as a citizen and resident of the Alpha Home. The Alpha Home has scheduled a directed inservice for all staff training on 5/26/2011. This inservice provided education as well as best practice training with examples to prevent residents to staff incidents. The update policy has been received by all staff along with the inservice training to prohibit any other</p>		05/28/2011

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	<p>A social services note, dated 04/13/2011, indicated a verbal incident between Resident #130 and the SSD on 04/12/2011.</p> <p>An interdisciplinary progress note, dated 04/15/2011, indicated Resident #130 had made a complaint to the Administrator regarding the incident on 04/12/2011.</p> <p>Review of the investigation report, dated 04/13/2011, indicated the incident had been investigated by the Administrator and a Social Services Consultant and resulted in disciplinary action for the SSD.</p> <p>An interview with the Administrator on 04/27/2011 at 10:15 A.M., indicated the incident had been investigated and reported to Indiana State Department of Health [ISDH] as an unusual occurrence.</p> <p>3.1-27(b)</p>				<p>miscommunications. This corrective action and training will be accomplished for all residents having the potential to be affected by this deficient practice. Others residents with the potential to be affected by this finding will be identified by: All the residents having the potential to be affected by this finding were identified by the interviewing process. The residents were made aware in their resident council meeting of the updated policy and the method for reporting an incident with or without allegations, All allegations are documented, investigated and submitted to the ISDPH in a prompt manner. The facility will continue to notify the families, the physicians and agency with notifications. Currently, the Alpha Home is submitting all reports to ISDPH.</p> <p><u>II. Other Residents with Potential to be affected by this finding will be identified by:</u></p> <p>All other residents having the potential to be affected by the finding had been re – interviewed. If there is a reportable then it is submitted to the department of health with the completed investigation and the appropriate corrective action. The reports are documented and submitted to medical records, and follow up completion submitted to the department of health within a five day follow up. The Alpha Home is currently submitting all reports to</p>		

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					<p>the Department of Health. The Alpha Home will continue to report in a prompt manner to the regulatory agency, the resident's family, and physician. These follow up reports will continue with prompt submission to the ISDPH via fax, and/ or written communication to ISDPH.</p> <p><u>III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u></p> <p>-</p> <p>-</p> <p>-</p> <p>The Administrator, DON and Unit Manager along with the interdisciplinary team reviews the behavior log, incidents and accidents at each morning managers meeting. The Alpha Home has also implemented the daily follow up for reporting with the concern/ communication forms, the staff assignment sheets and the retraining with documentation in the behavior log. Staff awareness with understanding any incident requires a written narrative from the staff person and self reporting in the first 24 hours. These practices have been implemented to ensure the deficient practice does not recur.</p> <p><u>IV. Corrective Actions will be</u></p>		

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					<u>monitored to Ensure Compliance</u> <u>by:</u> - <u>Administrator, DON, Unit</u> <u>Manager, and the interdisciplinary</u> <u>team will review the incidents,</u> <u>behavior logs, and staff</u> <u>assignment daily. All reports and</u> <u>finding submitted to the Quality</u> <u>Assurance at its regular</u> <u>scheduled monthly meeting. This</u> <u>practice will be on going for the</u> <u>next three months. The Quality</u> <u>Assurance Committee will review</u> <u>and make recommendation for</u> <u>continuous quality improvements,</u> <u>after three months the committee</u> <u>will determine if additional</u> <u>recommendation is necessary.</u> -		

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were completed for residents with fistulas (dialysis access site), pacemakers and anchored catheters for 3 of 13 residents reviewed for care plan</p>			F0279	<p>It is the policy of the Alpha Home that each resident receive and the facility provide the necessary care and services to to attain or maintain the highest practicable physical mental and psysocial well being in accordance with the comprehensive assessment and plan of care. Corrective action taken Related to this finding: Resident #146 care plan has been reviewed, the care plan has been updated to include checking the left arm fistula upon return from dialysis on the requested days by the physcian. The Resident # 146 is also monitored daily on each shift. The facility policy has been updated on dialysis care. All inservices will be completed by 5/28/2011 for all shifts on the dialysis policy and</p>		05/28/2011

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	<p>development in a sample of 15 (Resident #146, #114 & #170).</p> <p>Findings include:</p> <p>1. A current undated facility policy titled "Care Planning" and provided by the Director of Nursing (DON) on 4/28/11 at 9:20 A.M., indicated the following: "Policy: Health Care Plan meetings are scheduled routinely and after a significant change to enable the staff, family and residents to develop</p>				<p>the monitoring of the resident's fistula. Resident # 114 care plan has been updated and now has pacemaker and left upper arm fistula in the care plan. Resident #170 care plan address the foley catheter. <u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> Unit Charge Nurse will document on twenty four hour report log on any new physician order and physician responses for every shift and alert following shift of any new orders received. And notification in chart that MAR was sent to provide physician with current medication list. <u>III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u> Charge nurse will send current MAR to physician before or after taking a physician order to confirm all current medications that the resident is on. If resident is going to appointment a copy of the current medication list will go with resident on transfer. Charge nurse will document that MAR was sent to physician to confirm current medications that the resident is on and clarify any additional information necessary. Charge nurse will review also current medication list and clarify with physician should any issue arise. Physician's orders will be put on twenty four hour log for all residents that receive any new orders and be reviewed with current medications on MAR to</p>		

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	<p>an interdisciplinary plan that would allow the resident to reach his/her highest level of mental, physical, spiritual and psychosocial well-being. Procedural Guidelines: ... Measurable, time-framed goals are written for each problem/need listed."</p> <p>2. The record for Resident #146 was reviewed on 4/25/11 at 12:45 P.M.</p> <p>Diagnoses for Resident # 146 included but were not limited to Diabetes,</p>				<p>confirm any orders given and to alert staff of any possible drug interactions. nursing will continue monitor twenty four hour log everyday to confirm any new orders and to follow up on monitoring that the MAR was sent to the physician before or after a order and proper documentation that the current MARS was sent to physician. Unit Nurse Manager will monitor for information to be placed on the twenty four hour log sheet and review with Director of Nursing for compliance.</p> <p>The Alpha Home corrective action and monititioring plan ttio ensure compliance shall be accomplished by:</p> <p>The Inttierdisciplinary ttieam each week ttio conductti corrective action review ofi all ttihe auditttthese daily audittis sheettis completted by nurses and reviewed by ttihe inttierdisciplinary ttieam are submittted wittih ttihe audittis ttio ttihe Qualittiy Assurance committtee atti each monthihly meettiing corrective action fior sttiafi members fior non compliance submittted ttio ttihe committtee also The Qualittiy Assurance committtee will provide monititioring by</p> <ol style="list-style-type: none"> 1. The recommendattions firom ttihe audittis and corrective action sheettis 2. Review and recommendattion fior sttiafi discipline per faciilittity policy fior audittis 3. Ensure faciilittity care plan policy is updatteedttio accomplish updatteed 		

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	<p>end stage Renal Disease, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease and dialysis.</p> <p>A current physician's order, originally dated 10/27/10, indicated an order to check the left arm fistula upon return from dialysis for bruit and thrill on Tuesday, Thursday and Saturday.</p> <p>The record lacked a care plan for the resident's left upper arm fistula.</p> <p>During the daily</p>				<p>physician orders with the care plans changes.</p> <p>4. Updated dialysis policy with the fistula per the resident's care plan. Monitored compliance with quality assurance committee for corrective action by</p> <p>1. Staff who violate policy to receive the disciplinary action with committee recommendation</p> <p>2. The Quality Assurance committee will provide recommendations for continued audits or provide an additional course of action</p> <p>3. The Quality Assurance committee will monitor for the next three months based on 100% compliance of the audits. The Alpha Home is submitting this addendum for F-279 for monitoring to ensure compliance</p>		

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	<p>conference on 4/26/11 at 4:00 P.M., the care plan for the left upper arm fistula site was requested.</p> <p>During an interview with the Director of Nursing (DON) on 4/27/11 at 3:30 P.M., she indicated there was no care plan for the resident's left upper arm fistula.</p> <p>#3. The record for Resident #114 was reviewed on 04/25/11, at 12:35 p.m.</p> <p>Diagnosis included, but was not limited to ESRD (end stage renal disease), diabetes type II, and a history of CVA (cerebral vascular accident).</p> <p>A physician's progress note, dated 08/25/10, indicated Resident #114, "...pacemaker placement for 3rd degree heart block...."</p>						

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	<p>A hospital record, dated 04/04/11, indicated, "...pt [patient] here from ECF [extended care facility] due to concern about L [left] UE [upper extremity] ...fistula...returned from dialysis today and fistula looked swollen...."</p> <p>The record lacked documentation of a care plan for the left upper arm fistula for Resident #114.</p> <p>The record lacked documentation of a care plan for a pacemaker for Resident #114.</p> <p>On 04/25/11 at 4:30 p.m., a care plan for the left upper arm fistula and pacemaker for Resident #114 was requested from the DoN (Director of Nursing) and ADoN (Assistant Director of Nursing) in the end of day conference.</p> <p>On 04/25/11 at 8:15 a.m., during an interview, the DoN indicated no current care plan specific to the left upper arm fistula could be located.</p> <p>On 04/26/11, at 4:15 p.m., a care plan for the left upper arm fistula and pacemaker for Resident #114 was requested from the DoN, ADoN, and the Administrator in the end of day conference.</p>						

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F0282 SS=E	<p>On 04/27/11, at 12:50 p.m., the DoN, provided a care plan for the left upper arm fistula, dated, 04/27/11.</p> <p>4. Resident #170's record was reviewed on 04/25/2011 at 12:45 P.M., diagnoses included but were not limited to diabetes, CHF (congestive heart failure), urinary retention from penile edema, Alzheimer's, and GERD (gastroesophageal reflux disorder)</p> <p>A current Medication Administration Recap, dated 04/01/2011, indicated the resident had a 16 fr (french) Foley catheter. Physician orders included for staff to change the catheter bag every Friday.</p> <p>The record lacked documentation of a current care plan for the Foley catheter.</p> <p>An interview with the DON on 04/26/2011 at 8:45 A.M., indicated there were no care plans for the Foley catheter.</p> <p>3.1-35(a)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review,</p>			F0282	<p>F282 – Care Plans It is the policy of the Alpha Home that</p>		05/28/2011

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	<p>observation and interview, the facility failed to ensure physician's orders were followed for residents with orders for blood pressure monitoring (# 114), appropriate dose and medication (# 190, # 70) and discontinue a medication for (#130) for 4 of 15 residents reviewed for orders for blood pressure monitoring and medication errors in a sample of 15.</p> <p>Findings include:</p>				<p>each resident receive and the facility provide the necessary care and services to attain the highest practicable physical mental and psychosocial well-being in accordance with comprehensive assessment and plan of care. <u>Corrective Action Taken Related to this Finding:</u> The Alpha Home has updated its policy on dialysis care inclusive of the fistula sites. Resident#146, #114, and #170 care plans has been reviewed and the care plan addresses the resident's dialysis visits, pacemaker, and fistula area. Each visit to dialysis the resident will return with an updated progress note, additional information will be added to the resident's care plan. The MDS coordinator is utilizing the calendars for the scheduling of the care plans to include new physician orders, significant changes and related information for the resident's care plan. <u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> All other residents having the potential to be affected by the finding have had their care plans review with the internal audit. 100 percent of the care plans audits have been completed. The weekly monitoring will continue with the unit manager and the director of nurses. The unit charge nurse will comply by adding any new orders, significant changes,</p>		

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	<p>#1. The record for Resident #114 was reviewed on 04/25/11, at 12:35 p.m.</p>				<p>dialysis, or other pertinent information to the twenty hour report, for communication inclusion in the care plan. <u>III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u> All the residents care plan audits have been completed. Care Plans will additionally address new physician orders, significant, changes , updated progress noted from service provides and contributing information that address the resident care. All care plans are reviewed with the audit sheets, and resident updates are communicated for continuous quality improvement to the Quality assurance committee. <u>IV. Corrective Actions will be monitored to Ensure Compliance by:</u> The administrator, Don, and unit manager along with the interdisciplinary team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2011	
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	<p>Diagnosis included, but was not limited to, ESRD (end stage renal disease), diabetes type II, and history of CVA (cerebral vascular accident).</p> <p>The most recent recapitulation dated for April 2011, with an original physician's order dated 01/20/11, indicated amlodipine besylate 10 milligrams for every morning, "...hold for SBP [systolic blood pressure] [less than] 110...."</p> <p>The most recent recapitulation dated for April 2011, with an original physician's order dated 01/20/11, indicated hydralazine 25 milligrams for three times a day, "...hold for SBP [less than] 110...."</p> <p>The MAR (Medication Administration Record) for April 2011, indicated Resident #114 received amlodipine besylate 10 milligrams at 9:00 a.m., everyday from 04/01/11 through 04/25/11.</p> <p>The MAR for April 2011, indicated Resident #114 received hydralazine 25 milligrams at 9:00 a.m., on 04/01/11 through 04/25/11, at 1:00 p.m. on 04/01/11 through 04/07/11, 04/09/11, 04/10/11, 04/12/11, 04/14/11, 04/16/11, 04/17/11, 04/19/11, 04/21/11, 04/23/11, and 04/24/11 and 5:00 p.m. on 04/1/11 through 04/25/11.</p>						

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	<p>The MAR for April 2011, indicated Resident #114 blood pressure was recorded on 04/08/11 between 7:00 a.m. and 3:00 p.m.</p> <p>During an interview with the DoN (Director of Nursing) on 04/26/11 at 9:10 a.m., blood pressure readings for February, March and April for Resident #114 were requested.</p> <p>During an interview with the DoN on 4/26/11 at 10:50 a.m., the DoN provided Resident #114's blood pressure readings the DoN obtained from the nurses notes and the MAR. The DoN indicated the blood pressure readings should be taken and recorded on the MAR for the medications with hold orders. The DoN indicated the blood pressure readings did not correlate with the medication administration times.</p> <p>The hand written sheet of blood pressure readings received from the DoN on 4/26/11 at 10:50 a.m., included, but was not limited to: Resident #114's blood pressure was taken on 04/05/11 at 6:00 a.m., 04/17/11 at 6:00 a.m., 04/20/11 at 8:30 p.m., 04/23/11 at 7:30 p.m., 04/24//11 at 1:15 a.m., 04/24/11 at 9:15 p.m., 04/25/11 at unknown time, 04/25/11 at 12:00 p.m., and 04/25/11 at 5:30 p.m.</p>						

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	<p>2. The record for Resident #190 was reviewed on 4/27/11 at 9:45 A.M.</p> <p>Current diagnoses included, but were not limited to, ischemic heart disease, hypertension, diabetes mellitus, coronary artery disease, congestive heart failure, dementia, chronic obstructive pulmonary disease, and acute chronic renal failure.</p> <p>The April, 2011, Recapitulation of physician's orders indicated Resident #190 was to receive Namenda (to slow memory loss) 5 mg (milligrams) every morning and 10 mg daily at bedtime, originally ordered 3/15/11.</p> <p>During the Medication Pass observation on 4/26/11 at 8:30 A.M., LPN #1 administered two 5 mg tablets of Namenda to Resident #190. LPN #1 indicated at that time, she did not know why the pharmacy had not provided 10 mg tablets, only 5 mg tablets and when the supply was exhausted she would be requesting 10 mg tablets so she did not have to give two 5 mg tablets to Resident #190 every morning.</p> <p>The error was brought to the attention of the DON (Director of Nursing) on 4/26/11 at the 4:00 P.M. daily conference.</p> <p>3. The record for Resident #70 was</p>			F0282	<p>F282 – Care Plans It is the policy of the Alpha Home that each resident receive and the facility provide the necessary care and services to attain the highest practicable physical mental and psychosocial well-being in accordance with comprehensive assessment and plan of care. <u>Corrective Action Taken Related to this Finding:</u> The Alpha Home has updated its policy on dialysis care inclusive of the fistula sites. Resident#146, #114, and #170 care plans has been reviewed and the care plan addresses the resident's dialysis visits, pacemaker, and fistula area. Each visit to dialysis the resident will return with an updated progress note, additional information will be added to the resident's care plan. The MDS coordinator is utilizing the calendars for the scheduling of the care plans to include new physician orders, significant changes and related information for the resident's care plan. <u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> All other residents having the potential to be affected by the finding have had their care plans review with the internal audit. 100 percent of the care plans audits have been completed. The weekly monitoring will continue with the unit manager and the director of</p>		05/28/2011

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	<p>reviewed on 4/27/11 at 1:50 P.M.</p> <p>Current diagnoses included, but were not limited to, anemia, cataract, gastroesophageal reflux disease, glaucoma, hypertension, and senile osteoporosis.</p> <p>The April, 2011, Recapitulation of physician's orders indicated Brimonidine 0.2% eye drops were to be administered 1 drop into each eye three times a day, originally ordered 4/29/10. Resident #70 was also to receive Dorzolamide HCL 2% eye drops 1 drop into each eye 2 times a day, originally ordered 3/23/10. The recapitulation also indicated the Brimonidine was to be administered at 6:00 A.M., 2:00 P.M., and 10:00 P.M. The Dorzolamide was to be administered at 9:00 A.M., and 9:00 P.M.</p> <p>During the Medication Pass observation on 4/26/11 at 1:35 P.M., LPN #1 was observed administering the Dorzolamide eye drops to Resident #70 instead of the Brimonidine eye drops.</p> <p>The error was brought to the attention of the DON during the daily conference on 4/26/11 at 4:00 P.M.</p> <p>4. The record for Resident #130 was reviewed on 4/25/11 at 12:40 P.M.</p>				<p>nurses. The unit charge nurse will comply by adding any new orders, significant changes, dialysis, or other pertinent information to the twenty hour report, for communication inclusion in the care plan. <u>III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u> All the residents care plan audits have been completed. Care Plans will additionally address new physician orders, significant, changes, updated progress noted from service provides and contributing information that address the resident care. All care plans are reviewed with the audit sheets, and resident updates are communicated for continuous quality improvement to the Quality assurance committee. <u>IV. Corrective Actions will be monitored to Ensure Compliance by:</u> The administrator, Don, and unit manager along with the interdisciplinary team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee.</p>		

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	<p>Current diagnoses included, but were not limited to, partial complex seizure disorder, Parkinson's Disease, multi-infarct dementia, glaucoma, and cerebral aneurysm.</p> <p>The current, April, 2011, recapitulation of physician's orders indicated Resident #130 was to receive Prednisone 5 mg (milligrams) 1 tablet by gastrostomy tube every other day for 6 weeks, originally ordered 3/6/11.</p> <p>The March, 2011, MAR (Medication Administration Record) indicated the medication was started on 3/7/11.</p> <p>The April, 2011, MAR indicated the resident was still receiving Prednisone 5 mg on April 19, 21, 23, 25, and 27. The medication should have been discontinued on 4/18/11.</p> <p>During the daily conference on 4/27/11 at 3:30 P.M. with the Administrator, DON, and ADON, information regarding the Prednisone order and discontinue date was requested.</p> <p>At the time of the final exit conference on 4/28/11 at 2:00 P.M., no further information had been provided.</p>						

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F0371 SS=F	<p>3.1-35(g)(2)</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the kitchen staff followed proper hand washing, food handling and defrosting techniques for 61 of 63 residents.</p> <p>Findings include:</p> <p>1. During the initial tour of the kitchen on 04/25/11 at 8:35 a.m., and in the presence of Cook # 2, the following observations were made:</p> <p>At 8:35 a.m., four logs of packaged ground meat were observed sitting in a sink. The water was not running. The meat was cold to touch. The meat was not frozen on the surface to touch.</p> <p>At 8:40 a.m., Cook #2 was observed in the food service line with gloved hands. The cook reached for clean bowls underneath the sink, left the service line to retrieve butter from the refrigerator and</p>			F0371	<p>F- 371 Dietary It is the policy of the Alpha Home to ensure the kitchen staff follows proper hand washing, food handling, and defrosting techniques for the safety of the residents. <u>Corrective Action Taken Related to this Finding: The Alpha Home conducted a directed in service with Peers and Associates. This in service addressed the techniques of proper hand washing with at least the twenty second allotted time to wash hands correctly. The tray line service was addressed with corrections with the serving of food and the use of wearing clothes. These in-services occurred on 4/27/2011 and again on 5/11/11. The staff all signed acknowledgement statements for understanding the procedure with hand washing, food handling and the defrosting of foods. Policy updated for staff awareness with defrosting foods from the freezer to the walk-in refrigerator.</u></p> <p>II. Other Residents with</p>		05/28/2011

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	<p>returned to the serving line and served food. The cook then reached to the sink area and retrieved a pitcher of water. The pitcher of water was in a sink with egg shell fragments in the bottom of the sink. The water was poured into a tray of food on the service line. The cook served food with serving utensils. The cook left the serving line and went to the stove. The cook fired the burner, sprayed the pan with cooking spray and cracked raw eggs into the skillet. The cook returned to the serving line and served food with serving utensils. Cook #2 did not wash hands or change gloves.</p> <p>At 8:45 a.m., the cook indicated she was not aware of a policy for leaving the service line. The cook indicated, "When we are finished we wash our hands."</p> <p>At 8:55 a.m., Cook #2 left the service line and washed hands for 11 seconds.</p> <p>At 9:15 a.m., the four logs of packaged ground meat observed in the sink without running water.</p> <p>At 9:20 a.m., Cook #2 indicated the meat in the sink was removed from the refrigerator at 8:15 a.m. The cook indicated the meat was on the lunch menu.</p>				<p><u>Potential to be affected by this finding will be identified by:</u></p> <p>All residents that reside at the Alpha Home have the potential to be affected by this practice. Random monitoring will occur for staff members in the dietary. The dietary consultant will conduct random observation for compliance by identifying hand washing, wearing of gloves and defrosting.</p> <p><u>III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u></p> <p>- Retaining and redirection training will continue with the dietary staff. Staff violating the policy shall receive corrective action notification to ensure compliance is occurring every day in the dietary. The compliance audits shall be completed weekly and turned in the interdisciplinary for review. These random audits conducted by the consultant and the dietary manager weekly will be the validation for compliance.</p>		

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	<p>The menu for 04/25/11, indicated meat sauce as part of the lunch.</p> <p>At 9:45 a.m., during an interview with the DM (dietary manager), the DM indicated the staff were educated to wash hands after they "touch something they shouldn't."</p> <p>At 9:50 a.m., during an interview, the DM indicated the meat should go from freezer to the refrigerator to defrost. The meat should be used from the walk- in refrigerator.</p> <p>2. On 04/26/11 at 5:25 p.m., during the dinner service observation, Cook #3 was observed in the food service line with gloved hands. Cook #3 used a ladle to serve soup, moved trays in place, placed a resident name card on a tray, and picked up a deli sandwich with gloved hands to place on plate. Cook #3 moved the tray down the line, picked up the name card, and unwrapped cheese and placed a cheese slice on the plate with gloved hands. Cook #3 did not wash hands or change gloves between tasks.</p> <p>An undated policy provided on 04/27/11 at 10:45 by dietary, titled "Infection Control-Hand Cleaning and Drying," indicated the importance of hand washing. "...is one of the most important means of</p>				<p><u>IV. Corrective Actions will be monitored to Ensure Compliance by:</u></p> <p>-</p> <p>- <u>Dietary compliance shall be monitored by consultant and the Dietary Manager. Continuous Quality improvement to be validated by the audit completed each week. The audits to be presented quality assurance meetings. These audit/compliance sheets shall continue for the next three months and based on compliance under the recommendation of the quality assurance committee's the committee will decide if the audit monitoring compliance must continue, or make additional recommendation for sustaining the compliance.</u></p> <p><u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> All residents that reside at the Alpha Home have the potential to be affected by this practice. Random monitoring will occur for staff members in the dietary. The dietary consultant will conduct random observation for compliance by identifying hand washing, wearing of gloves and defrosting. <u>III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u> Retaining and redirection training will</p>		

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	<p>preventing the spread of bacteria and infection...lathered hands and arms are to be vigorously rubbed for at least twenty (20) seconds...Wash hands...after handling...eggs,...and working with ready to eat foods;...directly before touching ready-to-eat food or food contact surfaces; m. after engaging in other activities that contaminate the hands...."</p> <p>A policy dated 8/2010 provided on 04/27/11 at 10:45 a.m., by dietary, titled "Policy and Procedure Proper Way to Thaw Foods," indicated...1. Safe Methods of Thawing Include: a. Under refrigeration to keep temperature down 41 {degrees} or below b. under (70 {degrees} running drained water. c. In a microwave followed immediately by cooking and serving. d. As part of the conventional cooking process...."</p> <p>3.1-21(i)(2)</p>				<p>continue with the dietary staff. Staff violating the policy shall receive corrective action notification to ensure compliance is occurring every day in the dietary. The compliance audits shall be completed weekly and turned in the interdisciplinary for review. These random audits conducted by the consultant and the dietary manager weekly will be the validation for compliance. <u>IV. Corrective Actions will be monitored to Ensure Compliance by: Dietary compliance shall be monitored by consultant and the Dietary Manager. Continuous Quality improvement to be validated by the audit completed each week. The audits to be presented quality assurance meetings. These audit/compliance sheets shall continue for the next three months and based on compliance under the recommendation of the quality assurance committee's the committee will decide if the audit monitoring compliance must continue, or make additional</u></p>		

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F0504 SS=D	<p>The facility must provide or obtain laboratory services only when ordered by the attending physician.</p> <p>Based on record review and interview, the facility failed to ensure only lab tests with physicians orders were done for 2 of 13 residents reviewed for lab testing in a sample of 15 (Residents #130 and #190).</p> <p>Findings include:</p> <p>1. The record for Resident #130 was reviewed on 4/25/11 at 12:40 P.M.</p> <p>Current diagnoses included, but were not limited to, partial complex seizure disorder, Parkinson's Disease, multi-infarct dementia, glaucoma, and cerebral aneurysm.</p> <p>The recapitulation of physician's orders for April, 2011, indicated the only laboratory orders were for an annual chest x-ray, ordered on 11/22/10.</p> <p>The record contained results of the following lab tests and dates done: 1/14/11 BMP (Basic Metabolic Panel), Keppra level, CBC with Diff (Complete Blood Count with differential), and Lamictil level. 4/8/11 BMP, Keppra level, CBC with</p>			F0504	<p>F- 504It is the policy of the Alpha Home to provide laboratory services to meet the needs of the residents. CORRECTIVE ACTION TAKEN RELATED TO THIS FINDING: Resident # 130 and resident #190 have been audited for follow up and preventive measures with the laboratory as stated with the physician orders. The facility policy has been revised and updated for notification of lab services. The labs are now documented when received with written notification placed on the 24 hour report. The physician has been notified of any request for a repeat lab with nursing to carry out the order with the lab service. Laboratory orders and procedure training completed on by 05/28/2011. The nurse's in violation of recording and documenting the labs per the physician results will face immediate disciplinary action up to and including suspension with follow thru termination for repeat violations. Lab orders are reviewed daily and presented at the morning managers meeting, the documentation review record is listed on the 24 hour report and assessed daily by the unit manager and Director of Nurses. Monitoring is completed by the MDS, coordinator, Unit manager</p>		05/28/2011

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	<p>Diff, and Lamictil level.</p> <p>During the daily conference with the Administrator, DON (Director of Nursing), and ADON (Assistant DON) on 4/26/11 at 4:00 P.M., a request was made for information regarding these lab tests.</p> <p>During the daily conference with the Administrator, DON, and ADON on 4/27/11 at 3:30 P.M., the DON indicated the resident had been hospitalized in December and returned without these tests having orders to resume them from previously.</p> <p>2. The record for Resident #190 was reviewed on 4/27/11 at 9:45 A.M.</p> <p>Current diagnoses included, but were not limited to, ischemic heart disease, hypertension, diabetes mellitus, hypothyroidism, coronary artery disease, and acute chronic renal failure.</p> <p>The recapitulation of physician's orders for April, 2011, indicated the laboratory orders were: may have annual chest x-ray, ordered 10/5/10 PT/INR (Prothrombin Time/International Normalized Ratio - coagulation study) every Monday, ordered 10/5/10 CBC every 6 months, ordered 10/26/10</p>				<p>and Director of Nurses. <u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> Other residents having the potential to be affected by these findings are identified by: Record review daily by nursing staff, also physician order review in a twenty hour period by nursing staff. The facility has established a communication quality indicator correction sheet for residents receiving lab services. This quality assurance monitor tool assists the staff with monitoring residents who receive lab services with documented proof, and resident's labs that are not in compliance. <u>Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u> Retaining , redirection with the laboratory representative. Facility specific policy review by all to adhere to the policy and the standard for resident care services utilizing the laboratory. Violators will receive corrective action per Alpha Home policy including suspension and/or termination for non compliance. <u>Actions will be monitored to Ensure Compliance by:</u> <u>Staff members who violated the facility's policy on completion of records and accuracy of records shall receive the facility corrective action form. Repeat violators be subject to the Alpha Home disciplinary policy which include suspension and/or</u></p>		

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F0505 SS=D	<p>TSH every 3 months, ordered 12/20/10</p> <p>The record indicated the following tests and dates done: BMP (Basic Metabolic Panel) 1/10/11, 2/14/11, 3/14/11, 4/11/11 Hemoglobin A1c (measure of blood glucose) 1/3/11, 4/4/11 Lipid Panel, CMP (complete metabolic panel), CBC with Diff 3/7/11</p> <p>The record lacked orders for these tests.</p> <p>During the daily conference with the Administrator, DON, and ADON on 4/27/11 at 3:30 P.M., a request was made for information regarding these tests.</p> <p>At the time of the final exit conference on 4/28/11 at 2:00 P.M., no further information was provided.</p> <p>3.1-49(f)(1)</p> <p>The facility must promptly notify the attending physician of the findings.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of abnormal lab results for 1 of 13 residents reviewed for lab tests in a sample of 15 (Resident #130).</p> <p>Findings include:</p>			F0505	<p><u>termination. There will be a weekly review of all audits utilizing the 24 hour reports, record documentation and medication administration reviewed weekly also. These weekly audit sheets and compliance sheets are collected and review for distribution at the Quality assurance meeting; The Quality assurance committee will monitor monthly and make a determination to continue monitoring based On the accuracy of the medical record. The Quality Assurance Committee monitoring is set for the next three months. Upon review by the Quality assurance committee a determination shall be made to continue the audits or provide an additional change in policy..</u></p> <p>It is the policy of the Alpha Home for to establish and maintain laboratory services when ordered by the phphyscian.<u>Corrective Action Taken Related to this Finding:</u> Resident # 130 labs have been confirmed, labs reflect the the physcian order with the documentattion of the results into the nurses note and notification to</p>		05/27/2011

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	<p>The record for Resident #130 was reviewed on 4/25/11 at 12:40 P.M.</p> <p>Current diagnoses included, but were not limited to, partial complex seizure disorder, Parkinson's Disease, multi-infarct dementia, glaucoma, and cerebral aneurysm.</p> <p>The record indicated a Keppra level was drawn on 4/8/11. The results were received on 4/9/11, and printed on 4/10/11 according to the lab report. The results indicated the level "35" was high - normal 5 - 30. The previous level was 16.</p> <p>The lab results form and nurses notes lacked documentation of the physician being notified of the high level of Keppra - medication for seizures.</p> <p>The record lacked physician's orders changing the dose of the Keppra after the results of the elevated level were received.</p> <p>During the daily conference with the Administrator, DON (Director of Nursing), and ADON (Assistant DON) on 4/26/11 at 4:30 P.M., information showing the physician was notified was requested.</p> <p>On 4/28/11 at 8:15 A.M., the DON indicated she could not provide</p>				<p>the physician. Care plan updated with revisions and new approaches and interventions implemented. The nurses utilized their check off lists for monitoring and auditing labs orders documentation into the record. The MDS coordinator has reviewed all the care plans and now the care plans comply with the cushion being utilized in the plan of care for resident # 130. The Nursing staff received additional training for consistency with documentation physician orders and lab results. The unit nurses who are assigned the resident provide documented lab results per the physician order. All residents receiving labs will have their orders monitored and documented daily by the unit manager, and staff nurses will monitor for compliance. The 24 hour audits are being utilized and presented on the 24 hour report for review by the Unit manager and nurses for intervention with the assistance of the IDT team. Resident charts are brought to the meeting to document the care plans intervention and update resident progress. <u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> All residents receiving labs have the potential to be affected by this finding, however no other residents at present have been affected by this finding. <u>III. Measures and Systemic Changes put into Place</u></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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	documentation the Keppra level had been reported to the physician. 3.1-49(f)(2)				<u>to Assure Deficit Practices do not recur are as Follows:</u> Retaining and redirection training on the resident notification when lab levels is not appropriate or consistent with the physician order. Resident audit sheets at the morning managers meeting, Staff compliance is reviewed and corrections implemented with staff. Staff members and managers have the responsibility of monitoring and ensuring resident's receive their labs per the physician order. <u>IV. Corrective Actions will be monitored to Ensure Compliance by:</u> <u>Resident's labs needs shall be monitored by staff of the Alpha Home. Quality improvement monitoring and attendance shall be presented for resident compliance at the quality assurance meetings. These compliance sheets shall continue for the next three months and based on compliance under resident's choices the committee team will decide if the monitoring must continue.</u>		